Region of Peel
working with you

Housing Client Services - Medical Application Form for a Modified Unit

Important Information for Physicians and their Patients

Your patient has applied for community housing under the Housing Service (HSA) Act through the Region of Peel and is requesting a modified unit.

When completing the questions on this form please use plain language, print all comments and refrain from using abbreviations or acronyms.

Modified units will vary by housing provider and have varying degrees of modifications and accessibility. A modified unit is generally needed for household members who are confined to a wheelchair and/or will benefit from lowered counter tops. Some may have widened doorways and hall space, roll-in showers or modifications to allow an individual confined to a wheelchair to use the kitchen and bathroom.

All buildings that have modified units are accessible. Accessible building is defined by grade level access to accommodate wheelchairs, scooters and walkers.

Activities of daily living are considered to be everyday functions and activities individuals normally perform. These include: bathing, eating, dressing, ambulation and toileting.

Important: The following conditions do not qualify the patient for a modified unit:

- Grab bars
- Short term conditions (i.e. recovery from surgery)

Housing Client Services does not provide support services. If required, support must be in place to be eligible for subsidized housing.

Note: Your patient is responsible for any payments related to completion of this form.

Housing Client Services
10 Peel Centre Dr. Suite B, P.O. Box 2800, Brampton, ON, L6T 0E7
Phone: 905-453-1300
https://peelregion.ca/housing/

Consent and Release from Patient

I understand that Housing Client Services requires the requested personal health information to determine my eligibility for a modified unit.

☐ Yes ☐ No

I authorize my physician to release the information requested on this form to Housing Client Services, and I consent to Housing Client Services using, verifying and retaining this information on my centralized wait list file.

☐ Yes ☐ No

Patient's Name (printed) _____ Unique Key _____

Patient's Signature _____ Date (*mm/dd/yyyy*) _____

Patient Information

Before completing this form please ensure that you have read the front to understand under which circumstances an applicant is granted a modified unit.

NOTE: Our privacy statement is at the end of the form.

Please print when providing the information requested below.

Patient's Name

Patient's Date of Birth *(mm/dd/yyyy)*

Patient's Address

THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE PHYSICIAN

Before completing this form please ensure that you have read the front to understand under which circumstances an applicant is granted a modified unit.

Describe below the patient's disability or medical condition that requires a modified unit: ☐ ☐

Housing Client Services
10 Peel Centre Dr. Suite B, P.O. Box 2800, Brampton, ON, L6T 0E7
Phone: 905-453-1300
https://peelregion.ca/housing/

1. Is this patient in a wheelchair? ☐ Yes ☐ No

   a. If YES, how often is the patient in a wheelchair? ☐ Part-time ☐ Full-time

2. Is the patient able to bathe without a roll in shower? ☐ Yes ☐ No

3. Describe the modifications needed to the patient's accommodation to manage activities of daily living (i.e. widened doorways, lower countertops in kitchen and bathrooms, etc.):

Ability to Live Independently

Physician to complete

1. Is this patient currently able to live and function independently including the ability to manage the activities of daily living without assistance? ☐Yes ☐No

   a) If NO, explain. What support does the patient need?

Patient to complete (Only if the question above was answered NO)

2. Do you have the required supports noted above in place to help manage your activities of daily living? ☐Yes ☐No

   b) If YES, please list all supports/agencies currently in place:

Agency Name

Contact

Telephone

Note: Housing Client Services does not provide support services.

Physician's Release

I hereby certify that this information represents my best professional judgement and is true and correct to the best of my knowledge.

Physician's Name

Contact Telephone Number

Physician's Signature

Date *(mm/dd/yyyy)*

Physician's stamp	

Statement of Disclosure

The personal health information disclosed on this form will be used only for the purposes of determining an applicant's eligibility for a medical priority and is collected under the authority of the Housing Services Act, 2011 S.O. 2011 c. 6.

In applying for a medical priority, the applicant; who is in receipt of or applying for rent-geared-to-income assistance; consents to the collection, use and disclosure of the information on this form (including verification of the information) provided to Housing Client Services in their application or supporting documents.

Questions about the collection, use or disclosure of personal information, should be directed to The Regional Municipality of Peel, Human Services Department, Supervisor, Document Services, 10 Peel Centre Drive, Suite B, P.O. Box 2800, STN B, Brampton, ON L6T 0E7, or by telephone at 905-791-7800, extension 3577.